West Virginia Public Employees Insurance Agency

Maternity Benefit Prepayment Form

If you have questions call UMR: (888) 440-7342

OB Patient _____DOB: _____/_____/_____

Policyholder name_____ ID number_____

Address_____ City _____State_____ Zip_____

Home phone (_____) _____-_____ Work phone (_____) _____-_____

Other Insurance

Is patient covered under any *other* health insurance plan? ☐ Yes ☒ No **If yes,** complete the following:

Policyholder Name _____ Policy number_____

Name of group _____ Name of insurance company_____

TO BE COMPLETED BY PHYSICIAN

PEIA allows for payment of $500.00 prior to delivery for member after confirmation of pregnancy. To receive the prepayment, please complete the following:

Date of first OB visit _____ Expected date of delivery_____

This maternity benefit prepayment should be made payable to:

☐ Patient (Patient has paid $500.00 to physician. Physician must sign below as proof of payment.)

☒ Physician (Requires Assignment of Benefits from patient. Patient must sign below.)

Physician name (please print) _____

Physician address_____City_____State_____Zip_____

Phone number: (_____) _____-_____

Physician tax ID number_____

Physician signature_____ Date_____

Assignment of Benefits: I hereby authorize payment of this benefit to the above-named physician.

Patient's signature_____ Date_____

Please mail or fax completed form to:
UMR, PO Box 30541, Salt Lake City, UT 84130-0541 • Or fax to: 855-405-2189